



**Aging and Adult Services-  
Public Guardian  
Office of the Public Guardian**

**Sharon Nevins, LCSW, MA-PPM**  
Director-Public Guardian

Thank you for contacting the Office of the Public Guardian regarding obtaining the services from our office. In order for the Public Guardian to consider an individual for a possible probate conservatorship, you must complete the forms included in the referral packet. Please return the completed forms, along with a Capacity Declaration (GC-335) to the following address:

Office of the Public Guardian  
ATTN: Probate Investigations Unit  
686 E. Mill Street  
San Bernardino, CA 92415

It is critical for you to provide the requested information to conduct a thorough investigation. An investigation for probate conservatorship may take up to sixty (60) days to complete.

If you have any questions, please do not hesitate to contact the Office of the Public Guardian at (909) 798-8500.

Thank you for your time.

Sincerely,

Public Guardian  
County of San Bernardino

*Glenda Jackson*

GLEND A JACKSON  
Deputy Director/Chief Deputy Public Guardian

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## SAN BERNARDINO COUNTY PUBLIC GUARDIAN OFFICE

**Before filling out the application for an investigation for public probate conservatorship, please read the following information:**

**LEGAL CRITERIA:** Inability to properly provide for food, clothing, shelter, or physical health (conservatorship of the person) and/or substantial inability to manage financial resources, or resist fraud, or undue influence (conservatorship of the estate). The individual's incapacity must be measured and confirmed by the attending physician.

**GUIDING MANDATES:** A conservatorship is not an emergency response instrument. It may require as much as 8-12 weeks from the beginning of an investigation, to an actual court date. Additionally, legislation contemplates that a public probate conservatorship be the last resort and that all alternatives to such conservatorship be explored first. A public probate conservatorship may not be appropriate as a preventative measure. Generally an individual must meet the legal criteria at the time the referral is made.

### **I. FACTORS WHICH GENERALLY FAVOR A PUBLIC PROBATE CONSERVATORSHIP**

- A. The inability to think logically or exercise sound judgment. This is important when considering if the individual can provide for his/her own care and well being.
  - 1. Examples:
    - a. If multiple physical treatments are necessary and the individual lacks the ability to perceive: basic concepts of self care, diagnosis, options or treatment available; and is unable to give informed consent.
    - b. Severe memory loss resulting in the individual's being unable to discern whether his/her needs are being met such as payment for housing, meals, clothing, medications, etc.
    - c. Inability to choose an appropriate responsible individual to act on his/her behalf.
- B. A primary physical diagnosis which might also affect mental functioning such as stroke, Alzheimer's disease, etc. **OR** a primary physical disabling disease with a secondary mental impairment which does not require mental health treatment.
- C. No family members are able to provide care or act a conservator.

### **II. FACTORS WHICH GENERALLY DISCOURAGE A PUBLIC PROBATE CONSERVATORSHIP:**

- A. The individual has the ability to provide for and choose his/her own services (e.g. a person is in a nursing home, is alert and able to execute a power of attorney).
- B. A second party (e.g. friend family member, facility) is providing for all of the individual's needs.
- C. The individual has a primary diagnosis of mental illness or alcoholism which requires placement in a locked treatment facility.
- D. The individual presents a continual resistance to assistance (e.g. able to physically resist initial placement, willing and able to walk out of treatment or placement, able to articulate and justify reasons he/she objects to a conservatorship).
- E. Conservatorship is desired simply to facilitate medical consent or to pay bills.
- F. The individual is 'on the streets.' The Public Guardian cannot adequately conduct an investigation unless the individual is in some type of placement such as a hospital, home, facility, etc.

# **REFERRAL FOR INVESTIGATION FOR PUBLIC PROBATE CONSERVATORSHIP**

## **INSTRUCTIONS**

### **I. FACE SHEET (Page 1)**

1. Please fill out all personal information as completely as possible.
2. Relatives and Interested Parties – This should include names of any persons who have personal or professional connections to the proposed conservatee.

### **II. INCOME AND ASSETS (Page 2)**

1. Please give as much detailed information as possible regarding finances of the proposed conservatee.
2. Item 2 refers to Supplemental Security Income (SSI) which is administered by Social Security Administration.

### **III. DESCRIPTION OF CURRENT PROBLEMS AND LEVEL OF FUNCTIONING (Pages 3, 4, and 5)**

1. It is important that the referring party fully describe all known problems and circumstances associated with the proposed conservatee's incapacity, precipitating events, needs not being met, and level of care needed. Please be specific and use examples.
2. Be sure to sign the bottom of page 5.

### **IV. CAPACITY DECLARATION – CONSERVATORSHIP (Judicial Form GC-355)**

1. California Law requires that the court find deficits in mental functioning of the proposed conservatee before specific powers (i.e. authority to give medical consent, contract, execute a trust or make a conveyance) can be granted to the conservator.
2. **This declaration must be filled out and signed by the attending physician.**

**IMPORTANT – The document requiring physician input is necessary to satisfy legal requirements. If it is not filled out completely and signed by the physician, then the referral packet may be returned to the referring party.**

County of San Bernardino  
Office of Public Guardian-Conservatorship  
686 E. Mill Street  
San Bernardino CA 92415-0646

**REFERRAL FOR AN INVESTIGATION FOR PROBATE CONSERVATORSHIP**

**\*PLEASE ATTEMPT TO ANSWER EVERY QUESTION\***

Name: \_\_\_\_\_ AKA's: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widow(er)

Spouse's Name/Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Height (Approx): \_\_\_\_\_ Weight (Approx): \_\_\_\_\_

Currently:  Hospital  Nursing Home  Board & Care  Home  Other: \_\_\_\_\_

HOME ADDRESS & PHONE#:

CURRENT PLACEMENT ADDRESS & PHONE#:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Social Security #: \_\_\_\_\_

Medi-Cal #: \_\_\_\_\_

Medicare #: \_\_\_\_\_

Other Income: \_\_\_\_\_

Veteran's Status:  Yes  No Service #: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

In possession of DD-214:  Yes  No

**RELATIVES AND INTERESTED PARTIES**

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>Phone</u>	<u>Age</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Physician's Name, Address, Direct Phone#: \_\_\_\_\_  
\_\_\_\_\_

Prescription Medications (Please do not list "over the counter" medication)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## INCOME AND ASSETS

1. Social Security:  Yes  No Amount: \_\_\_\_\_
2. SSI:  Yes  No Amount: \_\_\_\_\_ VA:  Yes  No Amount: \_\_\_\_\_
3. Wages:  Yes  No Employer: \_\_\_\_\_ Amount: \_\_\_\_\_
4. Other Income/Assets: \_\_\_\_\_
5. Checking Account:  Yes  No Balance: \_\_\_\_\_  
Bank/Branch/Account #: \_\_\_\_\_  
Direct Deposits: \_\_\_\_\_
6. Savings Account:  Yes  No Balance: \_\_\_\_\_  
Bank/Branch/Account #: \_\_\_\_\_  
Bank/Branch/Account #: \_\_\_\_\_  
Direct Deposits: \_\_\_\_\_  
Type of Account (Trust, etc.): \_\_\_\_\_
7. Safety Deposit Box:  Yes  No Location: \_\_\_\_\_
8. Stock/Bonds/Securities:  Yes  No Type/Location: \_\_\_\_\_
9. Pension:  Yes  No Annuities:  Yes  No  
Name & Address of Company: \_\_\_\_\_
10. Real Property: Address: \_\_\_\_\_ Value: \_\_\_\_\_
11. Mobile Home: Address: \_\_\_\_\_ Value: \_\_\_\_\_
12. Vehicles: Location: \_\_\_\_\_ Description & Value: \_\_\_\_\_
13. Personal Property:  Yes  No  
Description & Location: \_\_\_\_\_
14. Insurance Policies:  Yes  No Type: \_\_\_\_\_ Company: \_\_\_\_\_
15. Burial Plans:  Yes  No Pre-Paid:  Arrangements: \_\_\_\_\_
16. Burial Plot/Crypt:  Yes  No Pre-Paid:  Location: \_\_\_\_\_
17. Will:  Yes  No Location: \_\_\_\_\_  
Power of Attorney or Trust:  Yes  No Name: \_\_\_\_\_

List Any Additional Information Below:

## ASSESSMENT OF SOCIAL/ MEDICAL NEEDS

It is important for our evaluation to include the following information. All referrals must address each area and be complete, if known. Skilled nursing facilities and hospital staff should be able to address all areas.

1. Is individual in a coma or has a terminal condition? \_\_\_\_\_  
(Life-sustaining devices used) \_\_\_\_\_
2. Orientation to person, place, time (Be specific): \_\_\_\_\_  
\_\_\_\_\_
3. Individual's knowledge of medical condition and medication: \_\_\_\_\_  
\_\_\_\_\_
4. If individual is in pain, to what degree? \_\_\_\_\_  
\_\_\_\_\_
5. Social and communication abilities: \_\_\_\_\_  
\_\_\_\_\_
6. Ability to follow instructions: \_\_\_\_\_  
\_\_\_\_\_
7. Ability to make needs known: \_\_\_\_\_  
\_\_\_\_\_
8. Grooming and eating abilities: \_\_\_\_\_  
\_\_\_\_\_
9. Bladder/ bowel control and frequency: \_\_\_\_\_  
\_\_\_\_\_
10. Mobility and aides used: \_\_\_\_\_  
\_\_\_\_\_
11. Ability to transfer from bed to wheelchair (If applicable): \_\_\_\_\_  
\_\_\_\_\_
12. Ability to cooperate with treatment and/or assistance (Specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ASSESSMENT OF SOCIAL/ MEDICAL NEEDS (Continued)**

13. Who secured current placement? \_\_\_\_\_  
\_\_\_\_\_

14. Monthly expenses and amounts (if known): \_\_\_\_\_  
\_\_\_\_\_

15. Where is the income mailed? \_\_\_\_\_  
\_\_\_\_\_

16. Prior address (if currently in acute hospital): \_\_\_\_\_  
\_\_\_\_\_

17. Does individual have any past or current history of violence, verbal, or physical aggression or acting out behaviors? If yes, please describe in detail. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. (Optional) Pertinent personal history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Continue to next page.**





ATTORNEY OR PARTY WITHOUT ATTORNEY NAME: FIRM NAME: STREET ADDRESS: CITY: STATE: ZIP CODE: TELEPHONE NO.: FAX NO.: E-MAIL ADDRESS: ATTORNEY FOR (name):	STATE BAR NUMBER           <b>FOR COURT USE ONLY</b>
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name):  <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	
<b>CAPACITY DECLARATION—CONSERVATORSHIP</b>	
CASE NUMBER:	
<p style="text-align: center;"><b>TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER</b></p> <p>The purpose of this form is to enable the court to determine whether the (proposed) conservatee (check all that apply):</p> <p>A. <input type="checkbox"/> is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for (date): . (Complete item 5, then sign and file page 1 of this form.)</p> <p>B. <input type="checkbox"/> has the capacity to give informed consent to medical treatment. (Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.)</p> <p>C. <input type="checkbox"/> has a major neurocognitive disorder (such as dementia) and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from medication for the treatment of major neurocognitive disorders (including dementia). (Complete items 6 and 8 of this form and complete form GC-335A; sign and attach form GC-335A. File pages 1 through 3 of this form and file form GC-335A.)</p> <p><i>If more than one item is checked above, sign the last applicable page of this form or, if item C is checked, form GC-335A. File page 1 through the last applicable page of this form; if item C is checked, file form GC-335A as well.)</i></p> <p><b>COMPLETE ITEMS 1-4 OF THIS FORM IN EVERY CASE.</b></p>	

**GENERAL INFORMATION**

1. (Name):
2. (Office address and telephone number):
3. I am
  - a.  a California-licensed  physician  psychologist acting within the scope of my license  with at least two years' experience in diagnosing and treating major neurocognitive disorders (including dementia).
  - b.  an accredited practitioner of a religion that calls for reliance on prayer alone for healing. The (proposed) conservatee is an adherent of my religion and is under my care. (Practitioner may make ONLY the determination in item 5.)
4. (Proposed) conservatee (name):
  - a. I last saw the (proposed) conservatee on (date):
  - b. The (proposed) conservatee  is  is NOT a patient under my continuing treatment and care.

**ABILITY TO ATTEND COURT HEARING**

5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. (Complete a. or b.)
  - a.  The proposed conservatee is able to attend the court hearing.
  - b.  Because of medical inability, the proposed conservatee is NOT able to attend the court hearing (check all items below that apply)
    - (1)  on the date set (see date in box in item A above).
    - (2)  for the foreseeable future.
    - (3)  until (date):
    - (4) Supporting facts (State facts in the space below or check this box  and state the facts in Attachment 5.)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name):	CASE NUMBER:
<input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	

## 6. EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS

**Note to practitioner:** This form is *not* a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.

**(Instructions for items 6A–6C):** Check the appropriate designation as follows: *a* = no apparent impairment; *b* = moderate impairment; *c* = major impairment; *d* = so impaired as to be incapable of being assessed; *e* = I have no opinion.)

### A. Alertness and attention

(1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)

a  b  c  d  e

(2) Orientation (types of orientation impaired)

a  b  c  d  e  Person

a  b  c  d  e  Time (day, date, month, season, year)

a  b  c  d  e  Place (address, town, state)

a  b  c  d  e  Situation ("Why am I here?")

(3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)

a  b  c  d  e

### B. Information processing. Ability to:

(1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)

i. Short-term memory a  b  c  d  e

ii. Long-term memory a  b  c  d  e

iii. Immediate recall a  b  c  d  e

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)

a  b  c  d  e

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)

a  b  c  d  e

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)

a  b  c  d  e

(5) Reason using abstract concepts (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)

a  b  c  d  e

(6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)

a  b  c  d  e

(7) Reason logically

a  b  c  d  e

### C. Thought disorders

(1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)

a  b  c  d  e

(2) Hallucination (auditory, visual, olfactory)

a  b  c  d  e

(3) Delusions (demonstrably false belief maintained without or against reason or evidence)

a  b  c  d  e

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior)

a  b  c  d  e

(Continued on next page)

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name):  <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	CASE NUMBER:
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6. (continued)

D. Ability to modulate mood and affect. The (proposed) conservatee  has  does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. (If so, complete remainder of item 6D.)  I have no opinion.

(Instructions for Item 6D): Check the degree of impairment of each inappropriate mood state (if any) as follows: a = mildly inappropriate; b = moderately inappropriate; c = severely inappropriate.)

Anger	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Euphoria	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Helplessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Anxiety	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Depression	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Apathy	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Fear	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Hopelessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Indifference	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Panic	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Despair	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>				

E. The (proposed) conservatee's periods of impairment from the deficits indicated in Items 6A-6D

- (1)  do NOT vary substantially in frequency, severity, or duration.
- (2)  do vary substantially in frequency, severity, or duration (explain; continue on Attachment 6E if necessary):

F.  (Optional) Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is  stated below  stated in Attachment 6F.

**ABILITY TO CONSENT TO MEDICAL TREATMENT**

7. Based on the information above, it is my opinion that the (proposed) conservatee

- a.  has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.
- b.  lacks the capacity to give informed consent to any form of medical treatment because he or she is either (1) unable to respond knowingly and intelligently regarding medical treatment or (2) unable to participate in a treatment decision by means of a rational thought process, or both. The deficits in the mental functions described in Item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

(Declarant must initial here if item 7b applies: \_\_\_\_\_.)

8. Number of pages attached: \_\_\_\_\_

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

\_\_\_\_\_  
(TYPE OR PRINT NAME)

\_\_\_\_\_  
(SIGNATURE OF DECLARANT)

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name):	CASE NUMBER:
<input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	

**ATTACHMENT TO FORM GC-335, CAPACITY DECLARATION—CONSERVATORSHIP,  
ONLY FOR (PROPOSED) CONSERVATEE WITH A MAJOR NEUROCOGNITIVE DISORDER**

9. It is my opinion that the (proposed) conservatee  HAS  does NOT have a major neurocognitive disorder (such as dementia) as defined in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*.

a.  Placement of (proposed) conservatee. (If the (proposed) conservatee requires placement in a secured-perimeter residential care facility for the elderly, please complete items 9a(1)–9a(5).)

(1) The (proposed) conservatee needs or would benefit from placement in a restricted and secure facility because (state reasons; continue on Attachment 9a(1) if necessary):

(2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9b(2) if necessary):

(3)  The (proposed) conservatee HAS the capacity to give informed consent to this placement.

(4)  The (proposed) conservatee does NOT have the capacity to give informed consent to this placement. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9a(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to placement in a restricted and secure environment.

(5) A locked or secured-perimeter facility  is  is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.

b.  Administration of medications. (If the (proposed) conservatee requires administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia), please complete items 9b(1)–9b(5).)

(1) For the reasons stated in item 9b(5), the (proposed) conservatee needs or would benefit from the following medications appropriate to the care and treatment of major neurocognitive disorders (including dementia) (list medications; continue on Attachment 9b(1) if necessary):

(2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9b(2) if necessary):

(3)  The (proposed) conservatee HAS the capacity to give informed consent to the administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia).

(4)  The (proposed) conservatee does NOT have the capacity to give informed consent to the administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia). The deficits in mental function assessed in item 6 of form GC-335 and described in item 9b(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to the administration of medications for the care and treatment of major neurocognitive disorders (including dementia).

(5) The (proposed) conservatee needs or would benefit from the administration of the medications listed in item 9b(1) because (discuss reasons; continue on Attachment 9b(5) if necessary):

10. Number of pages attached: \_\_\_\_\_

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: \_\_\_\_\_

\_\_\_\_\_  
(TYPE OR PRINT NAME)

\_\_\_\_\_  
(SIGNATURE OF DECLARANT)

Page 1 of 1